ANNUAL CERTIFICATE OF PHYSICAL CONDITION

DATE: _____

Instructions:

This certificate is to be completed annually by members of the naval service (including Reserves) as required by the Manual of the Medical Department and other directives, as appropriate **The intentional failure to disclose an illness or disease could be construed as an intent to defraud the Government and could result in the member's loss of disability benefits or be the basis for criminal prosecution or other administrative action under the Uniform Code of Military Justice.**

Type or clearly print member's name (last, first, middle initial); social security number; and unit to which assigned.

The member shall complete the appropriate responses, sign in ink, and date.

<table>
<tr><td colspan="3">1. Last Name, First Name, Middle Init.</td><td colspan="3">2. SSN</td><td>3. Rate/Rank</td></tr>
<tr><td colspan="2">4. Designator/MOS/NEC</td><td>5. Sex</td><td>6. Age</td><td colspan="3">7. Date of Birth</td></tr>
<tr><td colspan="4">8. Known Allergies</td><td colspan="3">9. Unit or School and UIC</td></tr>
<tr><td colspan="7">10. Home Address Street City</td></tr>
<tr><td colspan="7">11. State Zip + 4 Code Home Phone Number Work Phone Number</td></tr>
<tr><td colspan="4">12. Location of Health Record</td><td colspan="3">13. Location of Dental Record</td></tr>
<tr><td colspan="4">14. Date of last Complete Physical Examination</td><td colspan="3">15. Purpose of Examination</td></tr>
<tr><td colspan="2">16. Date of last Dental Exam</td><td colspan="2">17. Type of Examination</td><td>18. Class</td><td>19. Date of last PAP and results</td><td>20. Date of last Mammogram and results</td></tr>
<tr><td colspan="2">21. Date of last HIV Blood Test</td><td>22. Blood Pressure
Reserves Only</td><td colspan="2">23. Body Fat %</td><td>24. Height</td><td>25. Weight</td></tr>
</table>

(Continued on Reserve)

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1. Have you had any injury, illness or disease within the past 12 months which required hospitalization or caused you to be absent from school, duty or civilian occupation for more than 3 consecutive days?
   ( ) NO ( ) YES **If yes, explain:** _____

2. Are you now, or have you been under a physician's care during the past 12 months?
   ( ) NO ( ) YES **If yes, explain?** _____

3. Have you taken prescription medications in the past 12 months?
   ( ) NO ( ) YES **If yes, what are they?** _____

4. Do you have any physical defect(s), family or mental problems which might restrict your performance on active duty or prevent your mobilization?
   ( ) NO ( ) YES **If yes, explain:** _____

5. Additional comments: _____

Upon completion of indicated action, file completed certificate in member's Health Record and a copy in member's Dental Record.

I certify that the information contained in this form is true and complete to the best of my knowledge and belief.

MEMBER'S SIGNATURE: _____

MEDICAL DEPT. REP. SIGNATURE: _____

REVIEWING OFFICER'S SIGNATURE: _____

REVIEWING OFFICER'S COMMENTS: _____